Oct. 26. 2010 2:36PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 2367 P. 6/27

PRINTED: 09/28/2010

FORM APPROVED

<u>CFIN LEH</u>	12 LOW MEDICAHE	. & MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	CIVID INC.	1850-0581
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDEN/SUPPLIEN/CLIA IDENTIFICATION NUMBER;	(X2) M A. BU		IPLE CONSTRUCTION	(X9) DATE SURVEY COMPLETED	
		405450	B. WI	NG_		(. 1
		185490	<u> </u>			09/16	/2010
NAME OF PE	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST CLAIF	RE MEDICAL CENTE	R			222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(X4) ID PREFIX TAG	(EACH DESIGIENC)	STEMENT OF DEFICIENCIES Y MUST SE PRECEDED SY FULL SC IDENTIFYING INFORMATION	PREF	Х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE	(X6) COMPLETION DATE
F 000	INITIAL COMMEN		2 6		T N N		
	A Recertification/Al	bbreviated Survey was by 0 through 09/16/10, and a Life	क्षत्र अभिन्दर्भ	70301 NS	n ipareu.		20/02/2
	Safety Code Sun/a	by was conducted 09/14/10.			+225 - Corrective Ac		10/27/1
		cited with the highest Scope			taken at time of inc	ident	
		F". ARO #15267 was			since retroactive ch	art.	
,	substantiated with				Once DON was notifie	d on	
F 225	483.13(c)(1)(ll)-(lil)		F	225	$\frac{5}{8/23/10}$, a head to to		amont
88 ≖D	INVESTIGATE/RE						
	ALLEGATIONS/IN	DIVIDUALS			of resident #4 was c	omblete	la l
	The facility must n	ot employ individuals who have	1		by Charge Nurse, to d	ocument	
		of abusing, neglecting, or	•		current injuries. In	vestiga	tion
	mistreating resider	nts by a court of law; or have			was initiated immedi	_	
		red into the State nurse aide				-	
· ~~•·		g abuse, neglect, mistreatment			MD, Administrator, OIG		.Bo
		sappropriation of their property; owledge it has of actions by a			were notified 8/23/1	.0.	
		st an employee, which would			Don and Administrate	r revie	wed
		for service as a nurse aide or			current abuse policy	and	
		to the State nurse alde registry			investigation forms		
	or licensing author	rilles.	Ì		<u>-</u>		
	The facility must a	ungura that all atlaced violations			compliance with F225		
		nsure that all alleged violations ment, neglect, or abuse,			determined it was co	-	
	Including injuries of	of unknown source and			DON conducted Mandat	ory fac	Lity
		of resident property are reported			Staff training on 8/	24/10 °]
	· · · · · · · · · · · · · · · · · · ·	administrator of the facility and			to review entire abu	-	Lv
	I	a accordance with State law and procedures (Including to the			and reporting requir	_	1 -
		certification agency).					
					A quiz was used to d		ate
		nave evidence that all alleged			knowledge retention.		
		roughly investigated, and must			The RN that first sa	w the i	.hjury
	prevent further po	tential abuse while the			on this resident 8/2	2 but	
	I II AGORINALIOI IN ILL	hingings.			did not report it co		,
		investigations must be reported or or his designated			was counselled on 8/	_	
ABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that one safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days and the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 continued the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Adomistrator

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING			COMPLETED C	
		185430	B. WIN	G	•	_	/2010
	ROVIDER OR SUPPLIER RE MEDICAL CENTI			22	EET ADDRESS, CITY, STATE, ZIP CODE 22 MEDICAL CIRCLE IOREHEAD, KY 40351		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSQ IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	OMPLETION OATE
F 225	with State law (inc certification agend incident, and if the	page 1 d to other officials in accordance cluding to the State survey and cay) within 5 working days of the ealleged violation is verified clive action must be taken.	F2		New posters stating requirement and time were placed in staff lounge, conference rolocker rooms 9/29/10 All other residents given a complete hea	lines om,and . were	
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility falled to have an effective system to ensure all alleged violations involving abuse or injuries of unknown source were reported immediately to the Administrator of the facility and to State Agencies in accordance with state law for one (1) of four (4) sampled residents (Resident #4).				assessment on 8/23/1 and Charge Nurse, to for unknown injuries were found. Administrator and DO investigation proces reported 8/23/10 and	0 by DO assess None N revie s and f	wed orms
	Neglect, Involunt Misappropriation revealed "all alle mistrealment, ne of unknown sour resident property immediate super Administrator. T designee notifies Care; and the local Ombudsma State police, of a Review of Resid revealed diagnot Renal Disease (cillly's policy entitled "Abuse, ary Seclusion and of Property", dated 10/09 ged violations involving glect or abuse, including injuries ce, and misappropriation of are reported immediately to relate the Administrator or his/ her the OIG division of Long Term cal Adult Protection Services, the an and if appropriate the local or any alleged violation". Tent #4's closed medical record ses which included End Stage ESRD), Chronic Renai Fallure, and Sepsis of Urinary Origin.			in compliance apart "immediate reporting injury was found. Administrator and Di HR reviewed current states that persons of abuse/neglect/mis residents in a court are not hired to wor facility. This was v by HR Director and c employee files were evidence of criminal checks and checked a registry again and f	rector policy found g treatme of law k in th rerified current checked backgr	rse when of that uilty nt of e for ound abuse

CENTER	12 LOH WEDICAHE	& MEDICAID SERVICES				OMB NO.	<u> </u>
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X9) DATE 9U COMPLE	reo
		165430	B. WING			09/16	; 3/2010
NAME OF P	ROVIDER OR SUPPLIER			STA	REET ADDRESS, CITY, STATE, ZIP CODE		
ST CLAU	RE MEDICAL CENTE	R			22 MEDICAL CIRCLE		
0. 0LA				1	MOREHEAD, KY 40351		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 2	F	225			
	Review of the Adm	ission Minimum Data Set		1	Monitoring Process:		
		it dated 08/21/10 revealed the			Facility Administrato	r and D	OM
٠,		e resident as having no			receive abuse registr		
	impairment in cogr dialysis.	nitive skills and as receiving			1	-	
	dialysis.	Ì			reports from the stat		
-	Review of the Plan	of Care dated 08/10 revealed			review for any employ	ee name	S.
		t risk for Injury related to			Mock Abuse Reporting	will be	
		anti-coagulant medication) and			performed 10/26/10 to	evalua	te
	snould be observe	d for unusual signs and			staff response on all		l .
	aymptoma or blood	onig.			_ ·]
	Review of the facil	ity's Investigation entitled			Any shifts/persons fa	_	
		report Form" revealed an			this Mock investigati	on will	-
		completed related to the			he retested until the	y pass	
	•	and a fracture. The dialysis			correctly. This will	also be	
		the facility, the nurse noted the			performed annually by		
		creased confusion and			7 "	DOM	
		sk and shou <mark>lde</mark> r pain and the			Administrator.		
		ng to the shoulder and was			A Committee will com	ntinue	
		om the dialysis visit. The er stated, on 08/22/210 the	ļ		to review all incider	ıt	
		rulse to be worsening and the	1		reports quarterly, as	nd	
	resident complain	ed of discomfort. Continued			ensure appropriate an		ıΙν
		stigation, revealed the Physician			actions are taken per		ľ
		in x-ray was done of the right		•	· ·		ή.
		noted a Right Acromion review of the Investigation			Any aberrances will)		
	■	inistrator was notified on			addressed and staff	training	4
1		AM, the Office of Inspector			will occur.		1
		ied on 0B/23/20 at 3:00 PM and			HR Director will con	tinue to	
		Community Based Services 3/23/210 at 1:00 PM.			monitor abuse and cr		
	Was HUUMBU ON UE	DIZUZIU BU 1:00 MW.					
1	Review of the Nur	ree's Notes dated 08/21/10 at			background checks on		1
Ţ	7:00 AM revealed	the resident had "gone to			employees on an ongo	ing bas	1 S.
		of an entry dated 08/21/10 at					
	11:10 AM reveale	d upon return from dialysis the					}

Oct. 26. 2010 2:36PM No. 236/ P. 5

PRINTED: 09/28/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 185430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40351 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (XB) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** F 225 F225 Abuse policy will remain on Continued From page 3 patient was alert and seemed very confused. the monthly Facility Staff Further review of the Notes revealed safety precautions were in place, due to confusion. An Meeting agenda as a regular entry at 12:50 PM revealed the resident item to be reviewed with no complained of back and shoulder pain and medication was administered. end date. Review of the Nurses' Notes dated 08/21/10 (wrong date-should be 8/22/10 per interview with the Director of Nursing on 09/16/10 at 8:30 AM) at 8:00 AM revealed there was a large brulse noted to the resident's right shoulder and the resident complained of right shoulder pain, "Son stated he hurt it vesterday while at dlalysis". An entry at 10:00 AM revealed new Physician's Orders were received. An entry at 1:00 PM revealed the resident was off the floor for an X-Ray. An entry at 3:30 PM revealed an Orthopedic consult was ordered due to a fracture of the Acromion. Interview on 08/15/10 with Licensed Practical Nurse (LPN) #4 revealed she was assigned to the resident on 08/21/10, when the resident returned from dialysis. She further stated the residents' son brought the resident back from dialysis and stated he had stepped on the resident's catheter and almost dropped the resident while transferring the resident into the car. LPN #4 stated she assessed the resident and noticed bruising on the resident's abdomen and right shoulder. Further Interview revealed the bruising on the resident's right shoulder was light purple in color and was a little larger than a half dollar. LPN #4 stated she reviewed the chart and noted there was documentation of the resident having multiple bruising on the trunk and over the residents body. She further stated the resident

complained of pain and hurting all over and she administered pain medication. Continued

Oct. 26. 2010 2:36PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 2367 P. 10/27

PRINTED: 09/28/2010

OMB NO. 0938-0391

FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 185430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40851 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X6) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PAEFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG **DEFICIENCY**) F 225 Continued From page 4 F 225 interview, revealed she did not notify the Physician or Administration of the bruising or pain because after review of the medical chart, the resident already had bruising and the pain was not new. Interview on 09/15/10 at 3:00 PM with Registered Nurse (AN) #3 revealed she was assigned to the resident on 08/22/10 which was the day after the resident had been to dialysis. She stated she noted a bruise on the resident's back and a dark purplish raised bruise which was five (5) to six (6) inches across on the resident's right shoulder. She stated the resident was unable to explain where the bruises came from; however, the sonstated the resident fell at dialvsis. Further interview, revealed she notified the Physician and an X-Ray was ordered which revealed a fracture. She stated the brulses and fracture were injuries of unknown source; however, she did not think about the injury being possible abuse. Continued Interview revealed she had abuse training; however did not notify her supervisor or administration. During an Interview with the DON, on 09/16/10 at 8:30 AM, she revealed the bruising and fracture were not reported to her until 08/23/10. The DON indicated she had "preached" to the nurses in reference to Administration needing to be notified Immediately if there was an injury of unknown source. She stated the "ball was dropped" and Administration, and the state agencies should have been notified on 08/22/10 of the resident's Injury of unknown source. Interview on 09/16/10 at 10:30 AM with the Administrator revealed she was not notified of the residents bruising and fracture until 08/23/10 and

PAN OF CORRECTION (X1) PHOVIDER/SUPPLIENCLIA (X1) PHOVIDER/SUPPLIENCLIA (X1) PHOVIDER/SUPPLIENCLIA (X1) PHOVIDER/SUPPLIENCLIA			A. BUILDING			COMPLETED	
		185430	e. WIN	IG		00/10	; i/2010
	ROVIDER OR SUPPLIER RE MEDICAL CENTE		- 	29	EET AODRESS, CITY, STATE, ZIP CODE 22 MEDICAL CIRCLE IOREHEAD, KY 40351	<u> </u>	1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION BHO) CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	ULD BE	(X6) COMPLETION DATE
F 225	Continued From pa	age 5	F:	225	·		
F 226	she should have been notified "right away". F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES			226	F226 - Corrective Actaken at time of inc	CIOII	10/27/1
	The facility must d	evelop and implement written			since retroactive ch		İ
	policies and proce	dures that prohibit lect, and abuse of residents			Once DON was notified		
		Ion of resident property.			8/23/10,a head to to		sment
			•		of resident #4 was c		
·	This REQUIREMENT is not met as evidenced by: Based on Interview and record review, it was determined the facility failed to implement their Abuse Policy and Procedures regarding reporting injuries of unknown source immediately to the Administrator of the facility and to State Agencies				by Charge Nurse, to description of the current injuries. In was initiated immediated immediately. Administrator, OIC were notified 8/23/1	nvestiga Lately. Band DO	tion
	n accordance witr sampled residents The findings include	,			Don and Administrate current abuse policy investigation forms	y and	wed
	Review of the facility's policy entitled "Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property", dated 10/09 revealed "all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to immediate supervisor, Nurse Manager, and /or Administrator. The Administrator or his/ her designee notifies the OIG division of Long Term Care, and the local Adult Protection Services, the local Ombudsman and if appropriate the local or State police, of any alleged violation". Review of Resident #4's closed clinical record revealed diagnoses which included End Stage				determined it was conducted Mandata Staff training on 8, to review entire about and reporting required A quiz was used to knowledge retention. The RN that first as on this resident 8/2 did not report it contacts.	ompliant cory face /24/10 use polition rements demonstrict aw the 22 but correctly	ility cy ate injury
		SRD), Chronic Renal Failure,			was counselled on 8,	/25/10.	

PRINTED: 09/28/2010 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B, WING 186430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40351 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 226 Continued From page 6 New posters stating reporting F 228 Bladder Cancer, and Sepsis of Urinary Origin. requirement and time lines were placed in staff Review of the facility's Investigation entitled "Resident Abuse Report Form" revealed an lounge, conference room, and investigation was completed related to bruises locker rooms 9/29/10. and a fracture. The Investigation revealed the resident left for dialysis at approximately 6:30 AM All other residents were on 08/21/10 and was transported by the resident's given a complete head to the son's personal vehicle. The resident's son picked assessment on 8/23/10 by DdN up the resident at the dialysis clinic at approximately 11:15 AM and transported the and Charge Nurse, to assess resident back to the facility. The nurse noted the for unknown injuries. None resident to have increased confusion upon return to the facility. Further review of the investigation were found. revealed the dialysis clinic called to report the Administrator and DON reviewed resident had been agitated and confused while at the clinic. The resident complained of back and investigation process and forms shoulder pain and the nurse noted there was reported 8/23/10 and found it to be bruising to the shoulder and was unsure if it was from the the dialysis visit. The nurse on 08/22/10 in compliance apart from the noted the bruise to be worsening and the resident "immediate reporting" by nurse wheh complained of discomfort. According to the injury was found. Investigation, the Physician was notified and an x-ray was done of the right shoulder which Administrator and Director of denoted a Right Acromion Fracture. Further HR reviewed current policy that review of the Investigation revealed the Administrator was notified on 08/23/10 at 10:00 states that persons found guilty AM. of abuse/neglect/mistreatment of Review of the Nurses' Notes dated 08/21/10 (Per residents in a court of law, DON, on 09/16/10 at 8:30 AM, incorrect date, are not hired to work in the date-should be 8/22/10) at 8:00 AM revealed

there was a large bruise noted to the resident's right shoulder and the resident complained of

Physician's Orders were received. An entry in the

Nurse's Notes at 1:00 PM revealed the resident

right shoulder pain. "Son stated he hurt it

yesterday while at dialysis". An entry in the Nurse's Notes at 10:00 AM revealed new

facility. This was verified

employee files were checked for

evidence of criminal background

checks and checked against abuse

registry again and found to be in

by HR Director and current

PRINTED: 09/28/2010 FORM APPROVED OMB NO, 0938-0391

STATEMENT OF DEPICIENCIES		(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X9) DATE SURVEY COMPLETED	
			B. WING	<u></u>	С.	
		185430	B. WING	· · · · · · · · · · · · · · · · · · ·	09/16/2010	
	ROVIDER OR SUPPLIER REMEDICAL CENTE	A	2	EET ADDRESS, CITY, STATE, ZIP CODE 22 MEDICAL CIRCLE IOREHEAD, KY 40351		
(X4) ID PREFIX ,TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION	
F 226	the Nurses' Notes which stated an Ordue to a Fracture of the total process of the resident of the resident's back bruise which was fon the resident's rivesident was unable came from. She fut told her the resident interview, revealed an x-ray was order She stated the bruing funknown source about the injury be interview revealed however did not no administration. Interview on 09/16 of Nursing (DON) and noticed the lar shoulder and notifishe further stated not reported to her 08/23/10. Continuing preached" to the	ran X-Ray. Further review of revealed an entry at 3:30 PM, thopedic Consult was ordered of the Acromion. 10 at 3:00 PM with Registered ealed she was assigned to the 10 and she noticed a bruise on and a dark purplish raised live (5) to six (6) Inches acrossight shoulder. She stated the le to explain where the bruises wither stated the resident's son in fell at dialysis. Further I she notified the Physician and led which revealed a fracture, lises and fracture were injuries by however, she did not think ing possible abuse. Continued she had abuse training; wiffy her supervisor or 10 at 8:30 AM with the Director revealed RN# 3 worked 8/22/10 rege bruising on the resident's led the Physician. However, the bruising and fracture were or Administration until led interview revealed she had nurses in reference to	F 226	Monitoring Process: Facility Administrat receive abuse regist reports from the sta review for any emplo Mock Abuse Reporting performed 10/26/10 t staff response on al Any shifts/persons f this Mock investigat be retested until th correctly. This will performed annually b Administrator. QA Committee will co to review all incide reports quarterly, a ensure appropriate a actions are taken pe Any aberrances will addressed and staff will occur. HR Director will con	te and yee names. will be o evaluate l shifts. ailing ion will ey pass also be y DON/ entinue and and timely er policy. be training	
	if there was an inju- further stated the ' Administration, an have been notified injury of unknown	ation needing to be notified immediately is an injury of unknown source. She ted the "ball was dropped" and ation, and the state agencies should inotified on 08/22/10 of the resident's aknown source.		monitor abuse and cr background checks on employees on an ongo Abuse policy will re the monthly Facility	riminal all new oing basis. emain on	
TOP 11 011 011	Interview on 09/16	1/10 at 10:30 AM with the		Meeting_agenda_as a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TKQT11

Facility ID: 100704 To be reviewed with 110 Page 8 of 22 end date.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165430	B. WING		C 09/16/2010
	ROVIDER OR SUPPLIER RE MEDICAL CENT	b.	2	EET AODRESS, CITY, STATE, ZIP CODE 22 MEDICAL CIRCLE IOREHEAD, KY 40361	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TAYEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LEG (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 6H CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
F 226	residents bruising	page 8 ealed she was notified of the gand fracture on 08/23/10; uld have been notified "right		To corrective action	
F 279 SS=D	483.20(d), 483.20 COMPREHENSI A facility must us	VE CARE PLANS e the results of the assessment v and revise the resident's) ;	ossible for the clo hart of resident #4 ll current resident omprehensive Care P eviewed for accurac	's lans were
j. -1	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		1 1 1	ompleteness on 9/17 ON and MDS Coordina One were found to b Yew measures impleme Tloor nurse will con	tor. e deficient. nted -
	to be furnished to highest practicab psychosocial wel §483.25; and any be required under due to the reside	ust describe the services that are attain or maintain the resident's le physical, mental, and i-being as required under a services that would otherwise if \$483.25 but are not provided int's exercise of rights under g the right to refuse treatment (4).	1	nitiate admission c sing a care plan ch cool. The tool will equired care plans. cool will be given t coordinator to revie ccuracy and complet	eck list trigger The o MDS w for eness
	by: Based on observately it was de develop a Compathe resident's Colorated measur interventions to resident to resident to resident measur interventions to resident measurement measureme	IENT is not met as evidenced ration, interview and record termined the facility falled to rehensive Plan of Care based on imprehensive Assessment which able objectives and individualized neet the resident's needs for ampled residents (Resident	1	ow be developed by coordinator instead urse. MDS Coordinat receive a copy of earder written and witesponsible for updatolan.	the MDS of floor or will ch Physician ll be

Oct. 26. 2010 2:3/PM PRINTED: 09/28/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING С B. WING 185430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40351 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OF LSC (DENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 279 Continued From page 9 F 279 Random care plan audits will be done on 2 charts a The findings Include: week by DON or Administrator. Review of the facility "Comprehensive Care Plans" Policy revealed each resident "shall" have a comprehensive care plan which included measurable objectives and timetables to meet the resident's medical, nursing and psychosocial which were identified in the comprehensive assessment. Review of Resident #4's closed record revealed diagnoses which included End Stage Renal Disease (ESRD), Chronic Renal Failure, Bladder Cancer, and Sepsis of Urinary Origin. Review of the Admission Minimum Data Set (MDS) Assessment dated 08/21/10 revealed the facility assessed the resident as having no short or long term memory loss and as requiring limited to extensive assistance with Activities of Dally

Living. Further review of the MDS revealed the facility assessed the resident as receiving. dialysis.

Review of the Resident Assessment Protocol Summary (RAPS) dated 08/21/10 revealed the resident was admitted to the facility with Debility and other chronic medical comorbidities and was receiving dialysis.

Review of the Admission Physician's Orders dated 08/09/10 revealed the resident had a Right Udall catheter with Orders for dialysis Tuesdays, Thursdays and Saturdays. Review of the Nursing Assessment Flowsheets dated 08/09/10 through 08/25/10 revealed a section labeled "IV therapy"which stated the resident had a Udall catheter.

PRINTED: 09/28/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE: SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 185430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40351 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG OROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY** F 279 Continued From page 10 F 279 Review of the Comprehensive Plan of Care revealed a problem of ineffective tissue perfusion related to Renal Fallure. The goal stated the resident would have adequate tissue perfusion as evidenced by no edema, hypertension and/pr changes in laboratory data. There were several approaches included; however, the Plan of Care did not address the potential for infection related to the Udall catheter and did not specify the resident was attending dialysis three times per week. Interview on 09/16/10 at 8:30 AM with the Director of Nursing (DON) revealed neither the Plan of Care nor the Kardex which the nurses updated dally addressed the Udall catheter which was used for dialysis. The DON stated the catheter should have been addressed on the Plan of Care related to the risk for infection. The DON Indicated the plan should have included an Intervention regarding the resident going to dialysis three times per week. Interview on 09/16/10 at 12:00 PM with the MDS Coordinator revealed the staff nurses were responsible for developing the Plans of Care. She stated she completed the MDS and the Resident Assessment Protocols (RAPS) and gave the staff nurses a copy which included the areas which needed to be care planned. She stated each resident had a Care Plan Meeting on each Tuesday and the Plans of Care were reviewed. She stated she updated and revised the Plans of Care after the meetings when she noted there was an area that needed to be . addressed. She further stated Resident #4 should have had a Plan of Care developed related to the risk of infection with a Udali catheter and she was unsure why it was missed.

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OMB NO. 0638-0391 ONB NO. 0638-	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				APPROVED	
This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review if was adelermined the facility admitted residents (Residents (Reside	STATEMENT	NO BLALOR OR CONTRACT				(X3) DATE 8U COMPLET	RVEY TEO	
STREET ADDRESS, GTY, BYTE, ZIP CODE TAG PROVIDENT PLAN OF CORRECTION CROWNERS PLAN OF CORRECTION CROWNERS PLAN OF CORRECTION CROWNERS PLAN OF CORRECTION THOSE THOSE THOSE THOSE PROVIDENT PLAN OF CORRECTION PROVIDENT PLAN OF CORRECTION CROWNERS PLAN OF CORRECTION TO SEND CHOOSE PROVIDENT PLAN OF CORRECTION CROWNERS PLAN OF CORRECTION TO SEND CHOOSE THE SECULTORY ACTION AND CULD SE CROOSE REFERENCECTO ON THE PROPINITY CROWNERS PLAN OF CASE THOSE TO SEND CHOOSE THOSE TH	·		185430	B. WING		1	1	
Business was a processor of the resident for second property of the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observetion, interview, and record review it was determined the facility and the Palm of Care was sufficient to meet the needs of newly admitted residents (Resident #2 and #3.) The findings include: Review of the facility Comprehensive Care Plans Policy, revealed the resident mass admitted or expensive admitted resident was admitted all newly admitted resident was admitted to the facility admitted resident was admitted to the facility admitted resident was admitted to the facility from the hospital on 09/10/10 with disposes which included Lelf Acute Cerebral Vascular Accident. Further record review revealed the Admission Minimum Data Set (MDS) Assessment had not been completed due to the recent admission. Observation of the resident of 09/14/10 at 12:00 PM, 2:30 PM and 3:30 PM, revealed the resident had intravenous fluids influsing of 05 1/2 Normal Saline with 20 K+ (9% Dextrose Normal Saline with 20 K+ (9% Dextrose Normal Saline with 20 K+ (9% Dextrose Normal Saline with 10 MHz) and the resident of the resident and will be responsible for yupdating care plan.		•	3	1	222 MEDICAL CIRCLE			
The services provided or erranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility falled to ensure the Plan of Care was sufficient to meet the needs of newly admitted residents for two (2) of four (4) sampled residents (Resident #2 and #3). The findings include: Review of the facility Comprehensive Care Plans Policy, revealed 'there shall be regularly scheduled meetings that inlitted all newly admitted residents nursing care plans and to systematically maintain designated updates on in-house resident was admitted to the facility from the hospital on 09/10/10 with diagnoses which included Lelf Acute Cerebral Vascular Accident. Further record reliev revealed the Admission Minimum Data Sot (MDS) Assessment had not been completed due to the recent admission. Observation of the resident on 09/14/10 at 12:00 PM, 2:30 PM and 3:30 PM, revealed the resident had intravenous littled infusing of D5 1/2 Normal Saline with 20 K+ (5% Dextrose Normal Saline with twenty milliquivalents of Potassium) at 110 milliquivalents of Potassium) at 110 milliquivalents of Potassium) at 110 milliquivalents of conditions of potassium) at 110 milliquivalents of experiences.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPR	ULD RE	(X6) COMPLETION DATE	
revealed the resident was admitted to the facility from the hospital on 09/10/10 with diagnoses which included Left Acute Cerebral Vascular Accident. Further record review revealed the Admission Minimum Data Set (MDS) Assessment had not been completed due to the recent admission. Observation of the resident on 09/14/10 at 12:00 PM, 2:30 PM and 3:30 PM, revealed the resident had intravenous fluids infusing of D5 1/2 Normal Saline with 20 K+ (5% Dextrose Normal Saline with twenty milliquivalents of Potassium) at 110 ml	88#D	The services provide must meet profession. This REQUIREMENT by: Based on observation review it was determensure the Plan of the needs of newly of four (4) sampled #3). The findings include Review of the facility Policy, revealed "the scheduled meetings admitted residents in systematically main" in-house residents, disciplines in attend	ed or arranged by the facility onal standards of quality. It is not met as evidenced on, interview, and record nined the facility falled to Care was sufficient to meet admitted residents for two (2) residents (Resident #2 and comprehensive Care Plans are shall be regularly that initiate all newly nursing care plans and to tain designated updates on have all appropriate ance".	F 28	Resident #2 - plan of was updated by DON 9/to include IV fluids, care, and anticoagula Resident #3 - plan of updated by DON 9/17/1 to include anticoagula therapy. All other resident's plans were reviewed be and MDS Coordinator faccuracy and updated necessary. New measures implement floor nurse will continitiate admission causing a care plan che tool. The tool will to	IV site of the sit	e apy)
written and will be responsible for updating care plan.		revealed the resider from the hospital on which included Left. Accident. Further readmission Minimum had not been compleadmission. Observation of the rep., 2:30 PM and 3: had intravenous fluid	nt was admitted to the facility 09/10/10 with diagnoses Acute Cerebral Vascular ecord review revealed the Data Set (MDS) Assessment eted due to the recent esident on 09/14/10 at 12:00 30 PM, revealed the resident dis Infusing of D5 1/2 Normel		will be given to MDS to review for accurace completeness. Compreheare plan will now be developed by the MDS instead of the floor MDS Coordinator will	Coording and ensive Coording nurse.	ator	
CIVI LAVERS CONTRIBUTE MAN MAN AND AND AND AND AND AND AND AND AND A		with twenty milliquiva	alents of Potassium) at 110 ml		written and will be re	esponsil	ole	

		AND HUMAN SERVICES				PRINTED: FORM	09/28/2010 APPROVED
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AMPLIAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1ULT	IPLE CONSTRUCTION		0938-0391
à (CAIA Ó	I CONNECTION	IDENTIFICATION NUMBER:	A. BUI	ILDII	NG	COMPLE	
		185430	6. WI	NG_		C 09/16/2010	
NAME OF P	ROVIDER OR SUPPLIER		· A	\$T	REET ADDRESS, CITY, STATE, ZIP CODE	US/ I	WEDIO
ST CLAII	RE MEDICAL CENTE	1		2	222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ìΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 281	Continued From pa		F	281			-
	(one hundred and t	en milliliters) per hour. Further	•		Random care plan aud:		:
i	was in the left fores	ed the intravenous (IV) site			will be done by DON		
	1				Administrator (2 char	rts a w	eek)
	Heview of the Admi dated 09/10/10 at 9	ssion Physician's Orders :15 AM revealed orders for					
	intravenous fluids o	1 D51/2 NS at 110 ml /hr					
•	(5%Dextrose Norm	al Saline at one hundred and ur). Further review of the					, ·
	Physiclan's Orders	dated 09/11/10 at 7:30 AM					
	revealed orders for	four (4) runs of ten (10) y) potassium Intravenous (IV),					
	and forty (40) meq :	PO (by mouth) liquid K+					
	(potassium) now ar	d a repeat (Basic Metabolic					
,	dated 9/11/10 at 4:1	00 AM. Physician's Orders 10 PM revealed orders for NS					
, ·.	(Normal Saline) at	110 ml's per hour and a BMP					
	in the AM. Heview of the AM. Heview of the AM.	of the Physician's Orders :35 AM revealed orders for NS					
	+20 K at 110 cc/ hr	and four runs of 10 meg					
	potassium IV. Phys	sician's Orders dated 09/12/10					
	NS +20 K+ at 110 n	d orders to change to D51/2 nl/ hr.					
ι	Review of the Interl	m Plan of Care revealed there					
	was no Plan of Care	e to address the resident's					
	intravenous fluids o	r the need to monitor the					
	to the IV fluids. Also	ation or fluid overload related b, there was no Plan of Care to			1		`
	address monitoring	the IV site for signs and					
	symptoms of infecti	on or infiltration.		•			
	Further review of th	e Admission Physician's					
	Ordere dated 09/10	/10 revealed orders for illigrams (anti-platelet					
	medication)	, .					
	twice dally at mealti	me and Heparin Injection					
	medication) every e	ocutaneous) (anti-coagulant ight (8) hours. Further review					

PRINTED: 09/28/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY YN PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 185430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40351 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LISO IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 281 Continued From page 13 F 281 of the Physician's Orders dated 09/14/10 revealed Orders to discontinue Aggrenox and start Plavix 75 milligrams (anti-platelet agent). Review of the Plan of Care revealed the anticoaquiants/antiplatelets and complications and risk factors associated with the medications were not addressed. Interview on 09/16/10 at 10:20 AM with Registered Nurse (RN) #1 revealed she had completed the Interim Plan of Care for Resident #2 on the day the resident was admitted. She stated she was not assigned to the resident on the day of admission; however, she was assisting the admitting nurse. Further interview revealed at times the Physician's Orders were not available when the Plans of Care were completed and this may have been the reason she had not addressed the intravenous fluids, and the antiplatelet/anticoagulant medications on the Care Plan. She further stated, every nurse assigned to the resident was responsible for updating the Plan of Care. Continued interview revealed the resident should have had Plans of Care related to the intravenous fluids and the risk of infection/infiltration at the IV site. She further stated the Plan of Care should have addressed the antiplatelet/ anticoagulant medication due to the risk of abnormal bleeding. Interview with the Director of Nursing on 09/15/10 at 9:15 AM revealed the Admission nurse was to complete the Initial Plan of Care and the Plan of

Care was to be revised by the nurses with Physician's Orders. She further stated the team had a Care Plan meeting for each resident in the facility on Tuesdays and reviewed and revised the

Plans of Care at that time. She stated the

DEPART CENTE	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 09/28/2010 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE 8 COMPL	BURVEY LETED
		185430	e. wii	NG_			C 16/2010
ST CLAIR	PROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351		10/2010
(X4) ID PREFIX TAG	1 (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD RE	(X6) COMPLETION DATE
F 281	resident should have the risks involved we site, and the anti-planedications. 2. Resident #3 was diagnoses which incommon Hemorrhage, Hypotherical order for F (5,000) subcutaneo	ve had Plans of Care related to with intravenous fluids, the IV latelet/ anticoagulant is admitted on 09/09/10 with included. Right Intracerebral itension and Hyperlipidemia. It #3's Physician orders Heparin five thousand units ous (SQ) twice a day (BID) prevention of Deep Vein	F	281	<u> </u>		
,	Hesident #3's admissible to address the anticoagulation ther interventions were into Resident #3's new therapy.	of Care Plan developed upon ission revealed the care plan is resident was receiving rapy. Therefore, no in place to guide staff related reds regarding anticoagulation					
	on 09/16/10 at 9:15 prophylactically for I	nse Practical Nurse (LPN) #1 5 AM revealed Heparin SQ DVT does not require routine ulation lab work is managed ffice.			,		
	at 8:45 AM reveate a resident is admitted residents condition, medication. Further revealed it is not unasee the medication.	stered Nurse RN #1 09/16/10 ed a care plan is initiated when ed to the unit based on the , history, diagnosis and or interview with RN #1 ncommon for the nurse not to list for several hours following are plan for medication to get					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/28/2010 APPROVED 0938-0391
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NAME OF P	ROVIDER OR SUPPLIER		ـــــا	ОТ	TECT ADDRESS OVER AN AND AND AND AND AND AND AND AND AND	09/10	8/2010
STCLA	RE MEDICAL CENTER	<u> </u>		2	REET ADDRESS, CITY, STATE, ZIP CODE 22 MEDICAL CIRCLE MOREHEAD, KY 40351		:
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F 281	Continued From pa	ge 15	F 2	281	,		
	Further interview w related to anticoagu for Resident #3.	ith RN #1 revealed a care plan llation therapy was overlooked			·	.	
F 315 58=D	483.25(d) NO CATI RESTORE BLADD	HETER, PREVENT UTI, ER	F		Resident #2 -	,	10/25/10
	Based on the reside	ent's comprehensive			resident's medical h	-	1
	assessment, the fa	cility must ensure that a			was reviewed for need		
	resident who enters	the facility without an			indwelling catheter		
	indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract				MD was called and dis		1
					for need took place.		
•					determined that cathe		,
	infections and to re	store as much normal bladder			should be removed. Ca		
·• · .	function as possible	9 .			removed same day 9/1		
*	•				Current residents wit	ch	
	This REQUIREMEN	NT is not met as evidenced			indwelling catheters	were	╽ .
	by:	ion Interview and second			reviewed and assessed	1 for	
	review it was detern	ion, Interview and record mined the facility falled to			need by DON and Charg	je Nurse	
	ensure an indwellin	g catheter was not used			on 9/17/10. Actions (taken as	
	Uniess there was ve four (4) sampled re	alid Justification for one (1) of sidents (Resident #2).			appropriate.		
,	•	· .			Measures implemented	:	
ı	The findings include	9:			1. Urinary Incontiner		
	Review of Resident	#2's medical record revealed			assessment tool will		by
	the resident was ad	imitted to the facility from the			admitting nurse, on a		
	hospital on 09/10/10	0, with diagnoses which Cerebral Vascular Accident.			residents. Tool will		īv
	Further record review	w revealed the Admission			and determine type of		- 1
	Minimum Data Set	(MDS) Assessment had not			incontinence, bladden		
	neeu combleted du	e to the recent admission,			and risk for UTI and		.011,
	Observation of the	resident on 09/15/10 at 8:40			crigger for specific	-	
	AM revealed the re-	sident was in the bed and			interventions.	care p.	all
	annary oramage tu	oing was noted to be draining			THE CT ACTION ONLY	1	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			•	FORM	09/28/2010 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE 9L COMPLE	
		185430	B. WIN	ر <u>م</u> _			C .
NAME OF P	ROVIDER OR SUPPLIER		 -	STA	REET ADDRESS, CITY, STATE, ZIP CODE	09/10	8/2010
ST CLAI	RE MEDICAL CENTE	a		2	22 MEDICAL CIRCLE 10REHEAD, KY 40351		
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F 315			F:	315			
	yellow urine into the	urlnary drainage bag.	, ,		2. For residents add		
	Review of the Admi	ssion Physician's Orders			with an indwelling		l
	dated 09/10/10 reve	ealed Orders for a Foley			there is now a stand	•	der
	Cathter every shift a	and as needed (prn).			that allows facility	•	,
	resident had Impair to the use of a Fole Included observing	m Plan of Care revealed the ed urinary elimination related y catheter. The interventions for signs and symptoms of a			discontinue catheter does not meet LTC ro (listed on standing	egulation order)	one .
	Urinary Tract Infecti	on.			 Current catheter tool that is complete 	-	
	Further record revie evidence of a diagn indwelling catheter	w revealed there was no oses for the use of an		:	admission by MDS Coowill now have section	ordinate	or,
	V9/15/10 at 9:15 AN	irector of Nursing (DON) on I revealed she was unsure d a Foley catheter and she cord.		ı	which will include: a)checking for press a completed urinary tool and appropriate	assessi	
	9:00 AM and 11:00 guidelines the facilit evaluate the need for and after record revice condition did not fit stated the resident's have been removed due to there was not the catheter. The Did Director who was all Assistant (CNA) cor catheters were removed the catheter. She sit the catheter.	th the DON on 09/16/10 at AM revealed there were y referred to in order to or continuing a Foley catheter, lew the resident's medical the guidelines. She further indwelling catheter should after admission to the facility diagnoses or justification for ON revealed the Activities so a Certified Nursing inpleted audits to ensure Foley oved on new admits from the no medical justification for lated the CNA was on probably why Resident #2's been missed".			b) to determine if di and condition warrant continued indwelling use c) to check for prese of physician's order d) to address risks infection e) need for Urology of Areas identified as will be addressed ar corrected immediatel	agnosi: nts cather ence for consult deficiend	cer

		AND HUMAN SERVICES & MEDICAID SERVICES			*	FORM.	09/28/2010 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. ØU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
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NAME OF P	ROVIDER OR SUPPLIER			emo	REET ADDRESS, CITY, STATE, ZIP CODE	09/10	6/2010
ST CLAI	RE MEDICAL CENTEI	1	•	2	22 MEDICAL CIRCLE MOREHEAD, KY 40351		
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F 315	Continued From pa		F	315	All catheter audits a	are	
	enchoring/ maintain	y's "Diagnostic Guidelines for ling Foley Catheter" included:			reviewed at quarterly		
	Retention which co	uld not be controlled by in and			committee. Identified		3
	out caths and includ	ded a Physician's diagnosis.			will be addressed and		
	two hundred (200)	oid residual of greater than milliliters, contamination of a			actions will be taken		
	Stage III or Stage I\	/ wound where incontinence			appropriate.		
	terminal illness or s	de the healing process, or evere impairment which would					
	make positioning or	clothes change					
	uncomfortable or pa	ainful for the resident.					
F 37 1	discussion with the Foley and a diagnost be documented for of the Guidelines reneeded to be discontinuities the discontinuities of the di	her stated there should be a Physician on the reason for a sis or specific reason should the Foley. Continued review wealed Foley Catheters of the catheter falls under the accement or specific Physician ports it.	.	274	Immediately, kitchen checked by Director o	of food	10/5/17
88 <u>⊭</u> F	STORE/PREPARE	SERVE - SANITARY	F;		services for compliar		
	The facility must - (1) Procure food fro considered satisfac authorities; and	m sources approved or tory by Federal, State or local			this regulation. Any items found to be not compliance were disposimmediately. Any equifound to be not in compliance was cleaned santitized, and stored regulation immediatel	in psed of pment ed, re-	
. !	by: Based on observation	IT is not met as evidenced on, and interview it was illy failed to ensure food was			The flour scoop holde replaced so that the would be inside the boovered	er was	

DEPART CENTER	MENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVIÇES & MEDICAID SERVICES				FORM	09/28/2010 APPROVED
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185430			e, wi	NG.		I .	3
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			سبي د ماد	STREET AODRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	 -ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION CATE
F 371					A mandatory in-service conducted by Food Ser Director for all shif	ts on	10/5/10
	Observation of the kitchen during the initial tour on 09/14/10 at 10:00 AM revealed the walk in refrigerator contained a bag of donuts, a bag of chopped green peppers, and two (2) bags of chopped carrots which had been opened and were not labeled as to food Item or date opened in addition, a bottle of ketchup and a gallon container of salad dressing had been opened and were not labeled with an open date.				9/17/10 and 9/18/10. Staff reviewed policy re storage, preparation, distribution and serving of food under sanitary conditions per regulation. Deficiencies found during		,
, - 	Observation of the salad walk in refrigerator revealed a container of grated cheese and a container of parmesan cheese which had been opened and were not labeled with an open date. Observation of the refrigerator revealed two strawberry pies and two cherry pies which were uncovered.				the survey were review discussed. Systemic changes: 1. The shift supervise the responsible for re-	or will	
				•	be responsible for coall food safety and of sanitation audits each	lietary	
•	spices which were r including salt, sesar sage, bay leaves, b red crushed pepper	ervation of the dry storage area revealed es which were not labeled with the open date iding salt, sesame seeds, paprika, rubbed e, bay leaves, black pepper, seasoning salt, crushed pepper, poultry seasoning, burger seasoning, and red crushed pepper.			Any issues are correctimmediately. The Food Manager reviews audit corrections weekly and to Director Food Service.	Products and	·
	Further observation been left on top of the	revealed the flour scoop had ne flour bin.			2 During the current biweekly Inventory Pr		
	Interview with the Kitchen Supervisor, during the tour, revealed all items in the refrigerators were to be labeled as to contents and as to open date, and the ples should have been covered, labeled and dated. She further stated the cooks were.				in the kitchen, anoth step was added where products will be chec for appropriate label	all ked	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	09/28/2010 APPROVED	
BTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		OMB NO. 0938-0391 (X3) DAYE SURVEY COMPLETED				
185430		Ð. Wil	NG _		1	c		
NAME OF P	ROVIDER OR SUPPLIER	100.100		Τ		09/10	0/2010	
ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PAEF TAG	ΊX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFIGIENCY)	ULO BE	(X6) COMPLETION DATE	
F 371	Continued From pa	ge 19	F	 371				
	responsible for che	cking the refrigerators two	,	• • •	Kitchen remodelling a	also		
	times a day to ensu	ire this was done and to throw	began 10/25/10 which			will a	llow	
	deted The Kitcher	which was not labeled and Supervisor revealed "75% of			for more storage space	e and		
	the spices had not	been labeled when opened.			refridgerator space. This will			
	She further stated t	he spices were to be labeled			improve our ability to store,			
	with an open date a	and she had told the kitchen			prepare, distribute and serve			
	further stated spice	to ensure this was done. She is were good for six (6) months			food per regulation.	uid bel		
	to a year after open	ing, and after a year the		room por reguracton.				
ı	spices would lose (i	heir flavor, Continued				•		
	Interview revealed the Scoop holder had broken off the flour bin. She stated the scoop should not				MonItoring process:			
	have been placed o	on top of the flour bin, and			1. Food Production Manager of	hecks q-s	hift	
	should have been removed and washed after use.			audits and reports issues to Director Food				
n den.					Svcs.			
,	Interview on 09/14/	10 at 5:00 PM with the Cook			2. Biweekly inventory audit			
,	revealed he worked	6:00 AM to 2:30 PM and he			3. Dietary sanitation is now a f	ivad itam		
	checked the refrige	rators at the end of his shift.						
	He turther stated if	any food items were			for discussion at each monthly	/ starr		
	them away, at that t	or expired, he would throw time. Further interview			meeting		,	
	revealed he was ill	the prior day and was not at			4. Audits will be submitted to			
	the facility to check	the refrigerators; however, the			QA committee for review and	discussion) .]	
	checking the retrine	/as also responsible for prators at the end of the						
•	second shift,	stations at the end of the			İ			
F 441	483.65 INFECTION	CONTROL, PREVENT	F	441	Immediate corrective	action		
SS≂D	SPREAD, LINENS				· ·		1	
-	The facility must as	tablish and maintain an	٠		RN #1 immediately wen			
	Infection Control Program designed to provide a safe, sanitary and comfortable environment and				supervisor when the s		s	
					pointed out her error			
	to help prevent the of disease and Infe	development and transmission			glucometer was wiped		10/28/1	
	or Angerso and IIIIgi	UIION.			and set back in the c	radle		
	(a) Infection Contro				before any resident w	a 8		
	The facility must po	tablish an Infantion Control			Leenan			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 185430

PRINTED: 09/28/2010 FORM APPROVED OMB NO, 0938-0391

С 09/16/2010

(X6) COMPLETION

(X3) DATE SURVEY

COMPLETED

NAME OF PROVIDER OR SUPPLIER

(X4) ID

PREFIX

ST CLAIRE MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE

MOREHEAD, KY 40351

(D

PREFIX

TAG

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG F 441 Continued From page 20 Program under which it -(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation. should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

SUMMARY STATEMENT OF DEFICIENCIES

- (2) The facility must prohibit employees with a communicable disease or infected skin lesions
- from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
- (c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure there was an effective infection control program in place to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection.

The findings Include:

F441 All nursing staff

on the floor at the time were in-serviced by DON, on process of disinfecting glucometer between residents. A mandatory in-service for glucometer disinfecting for all nursing staff occurred on 9/21/10 and 9/22/10 for all shifts by DON. A bright sticker was placed on the glucometer to remind staff disinfect between residents. It was determined no other residents were affected by policy non-compliance by:

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

- 1. Charge Nurse continued to monitor existing residents for signs of infection i.e. temperature spikes.
- 2.9/17/10 administrator conducted "on the spot" audits to ensure staff were following infection control policy practices. Staff were corrected and re-educated as necessary.

rt. 26. 2010 2:39PM No. 236/ P.

PRINTED: 09/28/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING. 185430 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40361 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DAT CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 441 Administrator and DON reviewed facility Continued From page 21 F 441 infection control policy to ensure compliance Observation on 09/14/10 at 11:10 AM revealed with LTC regulations. It was determined to be Registered Nurse (RN) #1 wash her harids. compliant on 10/25/10. gather supplies, put on gown and gloves to provide care for a resident who was diagnosed Mandatory facility staff training on entile with Methicillin Resistent Staphylococcus Aureus infection control policy to be done 10/27/10. (MRSA). Quiz on infection control policy will be RN #1 was observed to perform an Accucheck given at end of in-service. on the resident, document the results and then removed her protective equipment (PPE). The Monitoring: RN then washed her hands and carried the 1. Pharmacy residents have Glucometer, without donning gloves and placed the Glucometer into the charging base. added "monitoring glucometer disinfection" to their quarterly med-paks Interview with RN #1 revealed the normal compliance observations. Compliance procedure was to sanitize the Glucometer with PDI Super Sani-Cloth, which was a germicidal. issues will be reported to QA committee and bacteriocidal, tuberculocidal and virucidal addressed sanitizing wipe approved by the Glucometer manufacturer. Further interview revealed she Administrator to continue "on the spbt" should have sanllized the Glucometer before infection control compliance checks replacing it on the base. RN #1 stated staff received glucometer training annually. one day a month. 3. All facility infections will continue to Review of the facility's Glucometer Policy dated be tracked and trended and reported to 02/19/09 and Procedure number 12-0110-10. revealed the Glucometer needed to be cleaned quarterly QA Committee where they are with a disinfectant prior to replacing the addressed. Glucometer on the charge base. 4. Infection Control Committee also Review of the Manufacturers maintenance and requires a monthly hand-washing and handling information revealed the acceptable disinfectant and/or cleaner for the Glucometer universal precautions/PPE audit were soap and water, 70% (or less) isopropyl be conducted and submitted by a alcohol or a 1:10 dilution of sodium hypochlorite facility clinician. ammonium compounds.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 185430 09/14/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE ST CLAIRE MEDICAL CENTER MOREHEAD, KY 40351 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 A Life Safety Code survey was initiated and concluded on 09/14/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F". 10/30/1b $K \, ^{144}|_{\mbox{As of } 10/4/10}$ quotes for a K 144 NFPA 101 LIFE SAFETY CODE STANDARD SS=F new annunciator or to move Generators are inspected weekly and exercised under load for 30 minutes per month in the annunciator from the accordance with NFPA 99. 3.4.4.1. switchboard to the ER registration, are in progress. A visible and audible annunciator (connected to emergency generator) will be located in the ER registration This STANDARD is not met as evidenced by: area which is staffed 24hrs Based on observation and interview, it was determined the facility falled to ensure the a day and 7 days a week. emergency generator had an annunciator panel Until new annunciator is according to NFPA codes. placed, a check of the The findings include: annunciator in the switchboard area will be added to the Observation on 09/14/2010 at 1:00 PM, revealed the emergency generator annunciator panel was rounds of the security team located at in the switchboard office. The each hour between 11.30pm observation was confirmed with the Maintenance Supervisor. land 6am. Interview on 09/14/2010 at 1:00 PM, with the Maintenance Supervisor, revealed the Switchboard Office was not occupied between the hours of 11:30 PM and 6:00 AM. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		DEWITTON NOWBER.	A. BUILDING	01 - MAIN BUILDING 01		
		185430	B. WING		09/1	4/2010
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREI 222 MC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
K 144	Continued From pa	age 1	K 144			
	shall be provided to generating room in operating personne (see NFPA 70, Nat 700-12.) The annunciator shall the emergency or a follows: (a) Individual visual following: 1. When the emergis operating to sup 2. When the batter (b) Individual visual audible signal to walarm condition shall. Low lubricating (2. Low water temporating 4.1.1.9) 3. Excessive water 4. Low fuel - when contains less than 5. Overcrank (faile	Annunciator. Itor, storage battery powered, or operate outside of the a location readily observed by all at a regular work station ional Electrical Code, Section half indicate alarm conditions of auxiliary power source as a signals shall indicate the gency or auxiliary power source ply power to load y charger is malfunctioning all signals plus a common arn of an engine-generator all indicate the following: oil pressure erature (below those required temperature the main fuel storage tank a 3-hour operating supply				
	periodically, an aud signal, appropriate at a continuously n derangement signal conditions in 3-4.1	ork station will be unattended dible and visual derangement ly labeled, shall be established nonitored location. This al shall activate when any of the .1.15(a) and (b) occur, but lesse conditions individually.				

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STEARER MEDICAL CENTER STALARE MEDICAL CENTER (X4) ID (GACH DESCRICENCY MAST REPRECEDED BY FULL AREQUATORY OR USO IDENTIFYING INFORMATION) A Life Safety Code survey was initiated and concluded in 09/14/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest acope and severity definitions as "F". K 144 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator had an annunciator panel according to NFPA codes. The findings include: Observation on 09/14/2010 at 1:00 PM, revealed the emergency generator annunciator panel was located at in the switchboard office. The observation was confirmed with the Maintenance Supervisor. Interview on 09/14/2010 at 1:00 PM, with the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` "	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCES CRACH DEFICIENCY SUPPLIED CRACH DEFICIENCY AUST BE PRECEDED BY PULL TABLE CRACH DEFICIENCY AUST BE PRECEDED BY PULL TABLE CRACH CORRECTIVE AGTONS SHOULD BE CHOSEN PROVIDED BY AN OF COARECTION (FRACH CORRECTIVE AGTONS SHOULD BE CHOSEN REPRECEDED BY PULL PROVIDED BY AN OF COARECTION (FRACH CORRECTIVE AGTONS SHOULD BE CHOSEN REPRECEDED BY PULL PROVIDED BY AN OF COARECTION (FRACH CORRECTIVE AGTONS SHOULD BE CHOSEN REPRECEDED BY THE APPROPRIATE OF CROSS REPRESENCED TO THE APPROPRIATE OF CROSS REPRESENCED TO THE APPROPRIATE OF CROSS REPRESENCED BY					· VI MIPAIR DUILDINGS DI		
ST CLAIRE MEDICAL CENTER 222 MEDICAL CENCLE MORPHEAD, KY 4055T			185430	B, WING		09/14/2010	
REGILATORY OR US OF DEPTIFYING INFORMATION TAG			R	8.	222 MEDICAL CIROLE		
A Life Safety Code survey was initiated and concluded on 09/14/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F". K 144 NEPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility falled to ensure the emergency generator had an annunciator panel according to NFPA codes. The findings include: Observation on 09/14/2010 at 1:00 PM, revealed the emergency generator annunciator panel was located at in the switchboard office. The observation was confirmed with the Maintenance Supervisor. Interview on 09/14/2010 at 1:00 PM, with the	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP	OULD BE COMPLETION	
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A visible and audible annunciator (connected to emergency generator) will be located in the ER registration area which is staffed 24hrs a day and 7 days a week. The findings include: Until new annunciator is placed, a check of the annunciator in the switchboard office. The observation was confirmed with the Maintenance Supervisor. A visible and audible annunciator (connected to emergency generator) will be located in the ER registration area which is staffed 24hrs a day and 7 days a week. Until new annunciator is placed, a check of the annunciator in the switchboard area will be added to the rounds of the security team each hour between 11.30pm and 6am.		NFPA 101 LIFE SA Generators are insunder load for 30 m	FETY CODE STANDARD Dected weekly and exercised inutes per month in	K 14	new annunciator or the annunciator from switchboard to the E registration, are in	the R	
Maintenance Supervisor, revealed the Switchboard Office was not occupied between the hours of 11:30 PM and 6:00 AM.		Based on observation determined the facing determined the facing determined the facing determined the facing determined to NFPA. The findings included the findings included the emergency generated at in the switch observation was consupervisor. Interview on 09/14/2 Maintenance Supers Switchboard Office hours of 11:30 PM	on and interview, it was lity failed to ensure the for had an annunciator panel codes. 14/2010 at 1:00 PM, revealed erator annunciator panel was litchboard office. The infirmed with the Maintenance 2010 at 1:00 PM, with the visor, revealed the was not occupied between the and 6:00 AM.		A visible and audible annunciator (connect emergency generator) located in the ER rearea which is staffe a day and 7 days a wuntil new annunciator placed, a check of tannunciator in the sarea will be added trounds of the securie each hour between 11	ed to will be gistration d 24hrs eek. r is he witchboard o the ty team	
	ABORATORY	DIRECTOR'S OR PROVID	11. 11	<i>o</i> /	A	. (X0) DATE	

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FORM CM8-2567(02-90) Previous Versions Obsolete

Event ID: TKGT21

Facility (D: 100704